Very rarely, the professional organisation of the involved physicians are invited to share their opinion on a specific item.
The criteria and modalities of reimbursement of lower limb prostheses has been revised in 2004. First, an 'evaluation' prosthesis is provided followed six months later by a permanent prosthesis, taking into account the classification of the patient in one of five defined functional categories. This functional classification determines the technical components that will be reimbursed for the confection of the prosthesis as well as the delay for renewal (between 3 and 10 years). An annual technical revision is also foreseen, thus, preventing technical defects of the prosthesis.
When the volume or the morphology of the stump shows a significant modification, a new socket can be reimbursed.
A physician specialised in PRM, surgery, rheumatology, neurology or paediatrics is required to fill in a document describing the clinical status of the patient and informing the prosthetist of specific clinical aspects that have to be taken into account.
The physician also has to ratify the functional category as proposed by the prosthetist when it concerns the categories 4 or 5, indicating the highest functional levels. However, this document is not a medical prescription sensu stricto.
The advantages and problems of this reimbursement system will be discussed more in detail during the lecture.
Pour en savoir plus
http://www.inami.be/care/fr/nomenclature/pdf/art29.pdf

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Organization and funding of physical and rehabilitation medicine in France

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Keywords: Physical and rehabilitation medicine; Care pathways; Funding; Organisation; France; Europe; SYFMER; SOFMER; COFEMER

There are 1850 PRM specialists in France. Three quarters of them are employees, 350 have an exclusive private practice and 150 share their activities between institutional and private practice.
French PRM is represented by a scientific society (SOFMER), a professional union (SYFMER) and a board of academic professors (COFEMER). Altogether, they make up the National Board of PRM, set up by law for supervising Continuing Professional Development and for advising the Government about health issues.
PRM private practices are often part of multidisciplinary and multiprofessional settings, either in the community or alongside a private hospital. Their activity is mainly focused on musculoskeletal impairments (93%), but 6% deal with pelvic floor issues and 1% with cognitive, sensory or cardiovascular/respiratory impairments. Patients pay for each consultation or technical act. Then, the National Health Insurance pays them back for the expenses.
Care facilities are divided into: (i) acute care settings (MCO) and (ii) post-acute and rehabilitation care settings (SSR). PRM takes place mainly within SSR. Those are sorted out in "versatile facilities" and "specialized facilities". Departments headed by a PRM specialist are usually classified as "specialised" in musculoskeletal and/or neurologic issues.
In the past, every care facility used to be funded on a daily cost basis. An activity based funding has been established in 2007 for MCO. But the Government has found more difficult to reach a relevant funding system for SSR, despite having collected plenty of management data for years.
The provisional funding model is based on four items: activity funding index, expensive drugs, specialised technical platforms and missions of public interest. SYFMER and SOFMER are claiming for an increased valuation of dependence criteria, of personal conditions, such as co-morbidity, cognitive impairments, behavioural troubles and precarious situations, as well as environmental factors with respect to ICF. All those conditions can reasonably explain an increase of care costs and longer stays in PRM departments than in versatile post-acute settings.
In this perspective, SOFMER is negotiating with public authorities for a pilot study on PRM care pathways for stroke patients
Further Reading
SYFMER: http://www.syfmer.org/
SOFMER: http://www.sofmer.com/
COFEMER: http://www.cofemer.fr/

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The CIF international classification: A model to fund SSR activities in France?

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Funding of PRM activity in France

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Keywords: Physical and rehabilitation medicine; Funding; Clinical activity; Technical activity; Public health; Insurance; SYFMER; Union; France

In PRM private practice, patients pay for each medical act and are refunded by the National Health Insurance (NHI). The price scale has been frozen for about ten years, but negotiations between Medical Unions and NHI seem to be starting again.
Clinical consultations (54% of the total number of acts) are divided into "Specialised Consultations" (CS = €23) and "Experts Opinions" (C2 = €46), which are evidenced by a letter to the patient's General Practitioner. Recently, the time period between two C2 consultations has been reduced from 6 to 4 months and a "Synthesis consultation" may be coded CS shortly after. French Union of Medical Specialists (UMESPE) is advocating for a better paid "Complex Clinical Consultation" (C3). French Union of PRM (SYFMER) has proposed a series eligible situations, such as "back pain persisting more than 3 months", "stroke patients after hospitalization" and "persisting pelvic floor impairments despite two previous primary treatments". SYFMER is also wishing for a "Clinical Functional Assessments", for the close supervision of multiprofessional programmes of care.
Technical activity is listed in the "Common Classification of Medical Acts–CCAM", shared by all specialties. In NHI database, 467,000 acts have been coded by PRM doctors in 2011–2012, using 443 different codes. Activity focused on musculoskeletal issues represents 92% of the total number of acts and is shared between vertebral therapy (28%), orthopaedic and traumatologic treatments (3%), hand orthoses (3%), punctures and injections (31%), X-ray and ultrasound imaging (15%), and ENMG (15%). Posture and movement assessment, together with sensory assessment, only account for 1.5%. Despite the reimbursement of isokinetic dynamometry since mid 2011, only 1230 related codes (0,3%) appear in this survey. However, SYFMER still asks for the refund of more functional assessment techniques, especially for Surface Topography in spinal diformities. Pelvic floor functional assessment in France accounts for only 6%. It is currently hindered by the high cost of sterile consumables, which SYFMER claims to be specially refunded. Cardior-espiratory and vascular assessmenst and rehabilitation remain marginal.
Further Reading
SYFMER: http://www.syfmer.org/

http://dx.doi.org/10.1016/j.rehab.2013.07.664